Class –XII **Psychology** **Psychological Disorders - Notes**

Major Psychological Disorders covered in the chapter are -

ANXIETY	DISSOCIATIVE DISORDERS	PSYCHOTIC DISORDER
OBSESSIVE COMPULSIVE AND RELATED DISORDER	DEPRESSIVE DISORDER	NEURODEVELOPMENTAL DISORDERS
TRAUMA AND STRESSOR-RELATED DISORDER	BIPOLAR AND RELATED DISORDER	DISRUPTIVE, IMPULSE-CONTROL AND CONDUCT DISORDER
SOMATIC SYMPTOM AND RELATED DISORDER	SCHIZOPHRENIC AND SPECTRUM DISORDER	FEEDING AND EATING DISORDER & SUBSTANCE RELATED AND ADDICTIVE DISORDER

Introduction: What is abnormal behaviour?

Most definitions of abnormal behaviour have certain common features, often called "four Ds":

1. **Deviance**: Psychological disorders are deviant- different, extreme, unusual, even bizarre.
2. **Distress**: Behaviour which is unpleasant and upsetting to the person and to the others.
3. **Dysfunction**: Behaviour which is interfering with the person's ability to carry out daily activities in a constructive way.
4. **Danger**: Behaviour which is dangerous to the person or to others.

Abnormal literally means "away from normal". It implies deviation from some clearly-defined norms or standards. There emerges two basic and conflicting views:

The **first approach** views abnormal behaviour as **deviation** from social norms.

The **second approach** views abnormal behaviour as **maladaptive** which states the best criterion for determining the normality of behaviour is not whether society accepts it but whether it fosters

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the well being of the individual and eventually of the group to which s/he belongs. Well being is not simply maintenance and survival but also includes growth and fulfilment.

"Physicians make diagnosis looking at a person's physical symptoms". How are psychological disorders diagnosed?

In order to diagnose psychological disorders, they are classified into categories.
The American Psychiatric Association (APA) has published an official manual describing and classifying various kinds of psychological disorders. The current version of it, the Diagnostic and Statistical Manual of Mental Disorders, V edition(DSM-V), evaluates the patients on five axes or dimension rather than just one broad aspect of 'mental disorder'. These dimensions relate to biological, psychological, social and other aspects.
The classification scheme officially used in India and elsewhere in the tenth revision of the **International Classification of Diseases** (ICD-10), which is known as the **ICD-10 Classification of Behavioural and Mental Disorders**. It was prepared by the World Health Organisation (WHO).

For each disorder, a description of the main clinical features or symptoms, and of other associated features including diagnostic guidelines is provided in this scheme.

Explain various models that describe abnormal behaviour.

MODELS OF ABNORMAL BEHAVIOUR

1. **Biological Model**: A wide range of biological factors such as faulty genes, endocrine imbalances, malnutrition, injuries and other conditions may interfere with normal development and functioning of the human body. These factors may be potential causes of abnormal behaviour. According to this model, abnormal behaviour has a biochemical or physiological basis. When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a neurotransmitter. Studies indicate that abnormal activity by certain neurotransmitters can lead to specific psychological disorders.
   - Anxiety disorders have been linked to low activity of the neurotransmitter gamma aminobutyric acid (GABA).
   - Schizophrenia to excess activity of dopamine.
   - Depression to low activity of serotonin.

2. **Genetic Model***:* Genetic model have been linked to mood disorders, schizophrenia, intellectual

disability and other psychological disorder. Researchers, however, have not been able to identify the specific genes that are culprits. It appears that in most cases, no single gene is responsible for a particular behaviour or a psychological disorder.

3. **Psychological Model***:* There are several models which provide a psychological explanation of mental disorders. These models maintain that psychological and interpersonal factors have a significant role to play in abnormal behaviour. These factors include:

- Maternal deprivation
- Faulty parent-child relationship
- Faulty discipline
- Maladaptive family structure
- Severe stress

The Psychological models include psychodynamic model, behavioural, cognitive and humanistic -existential models.

a) **Psychodynamic Model:**

- This is the oldest and most famous of the modern psychological models. Psychodynamic theorists believe that the behaviour, whether normal or abnormal, is determined by psychological forces within the person of which s/he is not consciously aware. These internal forces are considered dynamic, i.e. they interact with one another and their interaction gives to -shape, thoughts and emotions.
- Abnormal symptoms are viewed as the results of conflicts between these forces. The model was first formulated by Freud who believed that three central forces shape personality – instinctual needs, drives and impulses (id), rational thinking (ego), and moral standards (superego).
- Freud stated that abnormal behaviour is a symbolic expression of unconscious mental conflicts that can be generally traced to early childhood or infancy.

b) **Behavioural Model:**

- This model states that both normal and abnormal behaviours are **learned** and psychological disorders are result of learning maladaptive ways of behaving.

The model concentrates on behaviours that are learnt through conditioning and proposes that what

has been learned can be unlearned.

- Learning can take place by **classical conditioning** (temporal association in which two events repeatedly occur close together in time), **operant conditioning** (behaviour is followed by a reward) and **social learning** (learning by imitating others' behaviour). These three types of conditioning account for behaviour whether adaptive or maladaptive.

c) **Cognitive Model:** This states that abnormal functioning can result from cognitive problems. People may hold assumptions and attitudes about themselves that are irrational and inaccurate. People may also repeatedly think in illogical ways and make overgeneralisations, that is, they may draw broad, negative conclusions on the basis of a single insignificant event.

d) **Humanistic-existential Model:** This model focuses on broader aspects of human existence. Humanists believe that human beings are born with a natural tendency to be friendly, cooperative and constructive, and are driven to self-actualise i.e. to fulfil this potential for goodness and growth. Existentialists believe that from birth, we have total freedom to give meaning to our existence or to avoid that responsibility. Those who shirk from this responsibility would live empty, inauthentic and dysfunctional lives.

4. **Sociocultural Model:** Sociocultural factors such as war and violence, group prejudice and discrimination, economic and employment problems, and rapid social change, put stress on most of us and can also to psychological problems in some individuals. According to sociocultural model, abnormal behaviour is best understood in light of the social and cultural forces that influence an individual.

As behaviour is shaped by societal forces, factors such as family structure and communication, social networks, societal labels and roles become more important.

It has been found that certain family systems are likely to produce abnormal functioning individual members. Some families have an enmeshed structure in which the members are overwhelmed in each other's activities, thoughts and feelings. Children from this type of family may have difficulty in becoming independent in life.

The broader social networks in which people operate include their social and professional relationships. Studies have shown that people who are isolated and lack social support. i.e. strong and fulfilling interpersonal relationships in their lives are to become more depressed and remain

depressed longer than those who have good friendships.

Sociocultural theorists also believe that abnormal functioning is influenced by the societal labels and roles assigned to troubled people. When people break the norms of their society, they are called deviant and "mentally ill". Such labels tend to stick so that the person may be viewed as "crazy" and encouraged to act sick. The person gradually learns to accept and play the sick role, the functions in a disturbed manner.

5. **Diathesis-stress Model:** This model states that psychological disorders develop when a diathesis (biological predisposition to the disorder) is set off by a stressful situation. This model has three components:

- The first is the diathesis or the presence of some biological aberration which may be inherited.
- The second component is that the diathesis may carry a vulnerability to develop a psychological disorder. This means that the person is "at risk" or "predisoposed" to develop the disorder.
- The third component is the factors/stressors that may lead to psychopathology. If such "at risk" persons are exposed to these stressors, their predisposition may actually evolve into a disorder. This model has been applied to several disorders including anxiety, depression and schizophrenia.

Major Psychological Disorders

1. Anxiety Disorder

The term anxiety is defined as diffuse, vague and very unpleasant feeling of fear and apprehension. The anxious individual shows combination of following symptoms: Rapid heart rate, shortness of breath, diarrhea, loss of appetite, fainting, dizziness, sweating, sleeplessness, frequent urination and tremors.

Generalised Anxiety Disorder	**Panic Disorder**	**Phobia**	**Separation Anxiety Disorder**
Consists of prolonged, vague, unexplained and intense fears **that are not attached to any particular object.** **Symptoms**: • Worry and apprehensive feeling about the future. • Hypervigilance. • Constantly scanning the environment for dangers. It is marked by motor tension because of which a person cannot relax. He/she is restless, visibly shaky and tense.	Consists of recurrent anxiety attacks in which experiences intense terror. A panic attack an abrupt episode of intense anxiety rising to a peak when thoughts of a particular stimuli are present. Such thoughts occur in an unpredictable manner. The clinical features include shortness of breath,dizziness, trembling, palpitations, choking, nausea, chest pain, discomfort, fear of going crazy, losing control or dying.	Irrational fears related to a person, object or situation. Phobias are of three types:- 1. **Specific phobias-** includes irrational fears such as intense fear of certain type of animal or being into enclosed spaces. 2. **Social Phobias-** Intense & incapacitating fear & embarrassment when dealing with others in public. 3. **Agoraphobia-** When people develop a fear of entering into unfamiliar situations. They are also afraid of leaving their home, because of which they can't carry normal life activities.	Fearful and anxious about separation from attachment figures to an extent that is developmentally not appropriate. Children with SAD may have difficulty -being in a room by themselves -going to school alone -fearful of entering new situations -cling to and shadow their parents' every move. -To avoid separation, children with SAD may fuss, scream, throw severe tantrums, or make suicidal gestures

2. Obssessive-Compulsive and Related Disorders

People with OCD are unable to control their preoccupations with specific ideas or are unable to prevent themselves from repeatedly carrying out a particular act, which affect their ability to carry out normal activities.

Obsessive Behaviour- inability to stop thinking about a particular idea or topic.

Compulsive Behaviour- is the need to perform certain behaviours over and over again. For eg. Counting, touching, checking, washing etc.

E.g. Hoarding Disorder, Trichotillomania (hair pulling disorder), Excoriation (skin picking).

3. Trauma and Stressor-Related Disorder

People who are caught in natural disasters, bomb blasts, or have been in a serious accidents, or in a war situation, experience post traumatic stress disorder (PTSD).

Symptoms- Recurrent dreams, flashbacks, impaired concentration & emotional numbing. Includes- Adjustment disorder and Acute Stress Disorder

4. Somatic Symptom and Related Disorder

Are conditions in which there are **physical symptoms in the absence of a physical diseases**. The individual has psychological difficulties & complains of physical symptoms, for which there is no biological cause.

a) Somatic Symptom Disorder:

Persistent body-related symptoms which may or may not be related to any serious medical condition.

People with this disorder tend to be overly preoccupied with their symptoms and they continually worry about their health and make frequent visits to doctors.

As a result, they experience significant distress and disturbances in their daily life.

b) Illness Anxiety Disorder:

Involves persistent preoccupation about developing a serious illness and constantly worrying about this possibility. This is accompanied by anxiety about one's health. Individuals with illness anxiety

Overly concerned about undiagnosed disease, negative diagnostic results, do not respond to assurance by doctors, and are easily alarmed about illness such as on hearing about someone else's ill-health or some such news.

In the case of somatic symptom disorder, this expression is in terms of physical complaints while in case of illness anxiety disorder, as the name suggests, it is the anxiety which is the main concern.

c) Conversion Disorders:

Symptoms:

Reported loss of a body part or some basic bodily functions. For e.g Paralysis, blindness, deafness, difficulty in walking etc.

These symptoms often occur after stressful experience & may be quite sudden.

5. Dissociative Disorders

Dissociation- involves feelings of unreality, estrangement, depersonalisation & sometimes loss or shift of identity.

Dissociative Disorders- Sudden temporary alterations of consciousness that blot out painful experiences.

Dissociative Amnesia-	**Dissociative Identity Disorder**	**Depersonalisation/ Derealisation**
Is characterised by extensive but selective memory loss that has known organic cause (head injury). Some people cannot remember anything about their past, others don't remember specific events, people, places and objects, while other memories remain intact. It is associated with overwhelming stress. **Dissociative Fugue** An unexpected travel away from home and workplace. Assumption of a new identity Inability to recall previous identity Fugue usually ends when the person suddenly wakes up with no memory of events that occurred during fugue.	Also known as Multiple Personality Disorder. Associated with traumatic experiences in childhood. The person assumes alternate personalities that may or may not be aware of each other	Involves a dream like state in which the person has a sense of being separated from both self and reality. There is a change of self- perception, & the person's sense of reality is temporarily lost or changed.

6. Depressive Disorder/ Depression:

One of the most widely prevalent and recognised of all mental disorders is depression. Depression covers a variety of negative moods and behavioural changes. Depression can refer to a symptom or a disorder.

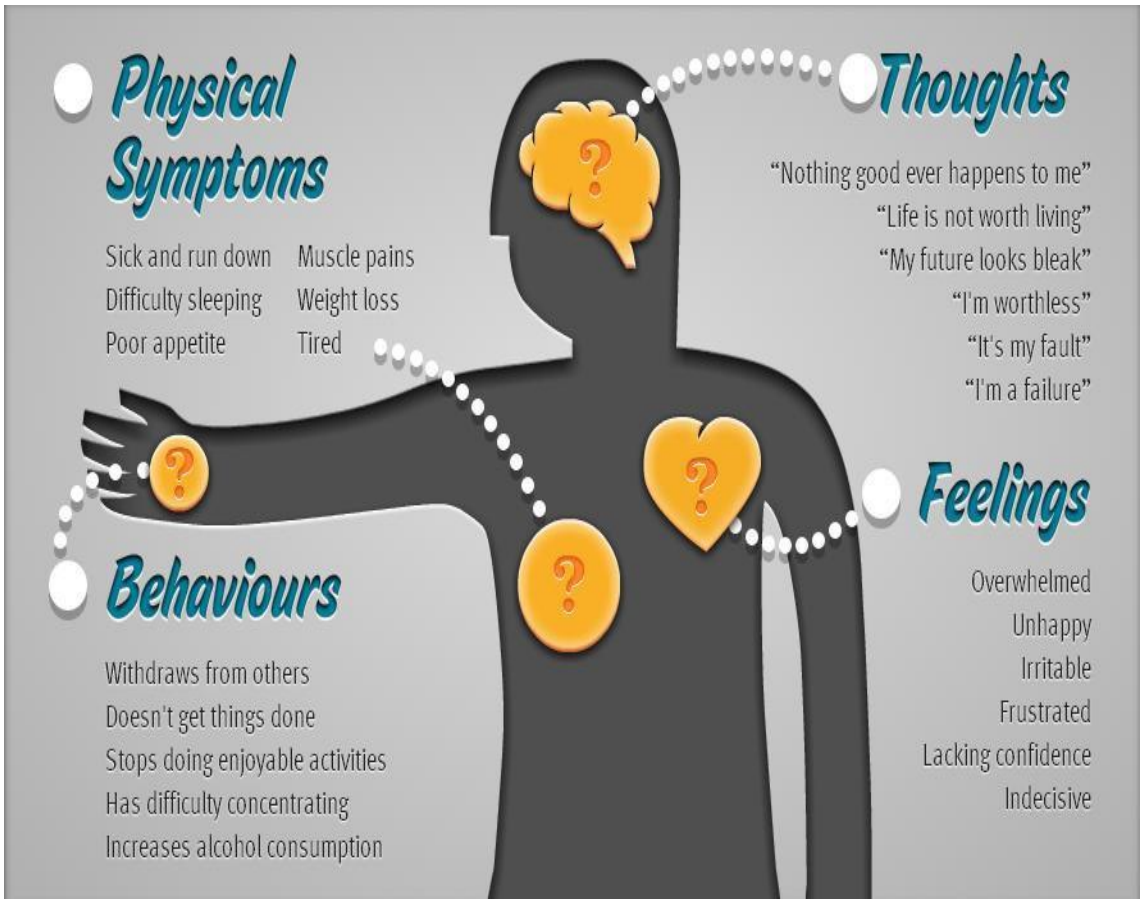
In day-to-day life, we often use the term depression to refer to normal feelings after a significant loss, such as the break-up of a relationship, or the failure to attain a significant goal.

Major Depressive disorder-

is defined as a period of depressed mood &/or loss of interest or pleasure in most of the activities together with other symptoms which may include change in body weight constant sleep problems, tiredness, inability to think clearly, agitation, greatly slowed behavior, thoughts of death & suicide, excessive guilt or feelings of worthlessness.

Factors predisposing towards depression-

- Age - For eg. Woman are at risk during young adulthood & men during middle age.
- Heredity – is a major risk factor predisposing people to mood disorders.
- Gender- For. Eg woman in comparison to men are likely to be more depressed.
- Other factors- For eg. Negative life events and lack of social support.



7. Bipolar and Related Disorder

Mania –	**Suicide**	**Factors leading to suicide**
People suffering from mania become Euphoric (high), extremely active, extremely active, excessively talkative, and easily distractible. ▪ Manic episodes rarely appear by themselves, they usually alter with depression. ▪ Such a mood disorder, in which both mania and depression are alternatively present, is sometimes interrupted by periods of normal mood, this is known as Bipolar Mood Disorder.	**Symptoms of Suicide** 1. Changes in eating & sleeping habits. 2. Withdrawal from friends family and regular activities. 3. Violent actions, rebellious behavior, running away 4. Drug and alcohol abuse. 5. Marked personality change 6. Persistent boredom 7. Difficulty in concentration 8. Complaints about physical symptoms 9. Loss of interest in pleasurable activities.	1. Social , psychological, cultural and other factors such as mental disorders (especially depression and alcohol use disorders), going through disasters, violence, abuse or loss and isolation. Impulse during crisis the capacity to deal with life stresses such as financial issues, relationship break-up etc. breaks down. Previous suicidal attempt is the strongest risk factor. Causes: inter -personal relationships, family and negative peer- pressure. The ramifications of suicide on social circle and communities tend to be devastating and long-lasting.

8. Schizophrenia Disorders

Schizophrenia is the descriptive term for a group of psychotic disorders in which personal, social and occupational functioning deteriorates as a result of disturbed thought processes, strange perceptions, unusual emotional states and motor abnormalities.

Symptoms: can be grouped into 3 categories- Positive (i.e. excesses of thought, emotion and behaviour), Negative (deficit of thought, emotion and behaviour) and psychomotor symptoms.

1. **Positive Symptoms:** pathological excesses or bizarre additions to a person's behaviour.

Symptoms: Delusions, disorganized thinking and speech, heightened perception and hallucinations.

Q: What are Delusions:

Delusions – false belief that is firmly held on inadequate grounds.

Delusions of persecution- They believe plotted against, spied on, slandered, threatened, attacked or deliberately victimized.

Delusions of reference- in which they attach personal meaning to the actions, objects and events

Delusions of grandeur-They believe themselves to be specially empowered.

Delusions of control- They believe their thoughts, feelings and actions are controlled by others.

Q: What are Hallucinations?

A: Perceptions that occur in absence of external stimuli.

They are of several types-

Auditory Hallucinations: Patients hear sounds or voices that speak directly to them.

Tactile Hallucinations: Tingling, burning sensations.

Somatic: Something happening inside the body, such as snake crawling inside stomach.

Visual: Distinct visions of people and objects.

Gustatory: Food or drink taste strange.

Olfactory: Smell of poison or smoke.

1. **Negative symptoms**: are pathological deficits and include **Alogia** (reduction in speech content or poverty of speech), **Blunted effect**– Less expression of sadness, joy, anger and other feelings.

Flat effect- No emotions and feelings

Loss of volition- Apathy or inability to start or complete any work.

Social withdrawal- become focused on their own ideas and fantasies.

1. **Psychomotor symptoms**: Less spontaneous, make odd grimaces and gestures. Types:

Catatonic stupor: remain motionless and silent for long durations.

Catatonic rigidity: maintain a rigid upright posture for hours.

Catatonic posturing: assuming odd, awkward positions.

9. Disruptive, Impulse-Control and Conduct Disorder

1. **Oppositional Defiant Disorder (ODD)-** display age-inappropriate amounts of **stubbornness**, are **irritable, defiant, disobedient**, and behave in a **hostile** manner. Unlike ADHD, the rates of ODD in boys and girls are not very different.	**2. Conduct Disorder** and **Antisocial Behaviour** refer to age inappropriate actions and attitudes that **violate family expectations, societal norms**, and the personal or property rights of others. The behaviours typical of conduct disorder include aggressive actions that **cause or threaten harm** to people or animals, non-aggressive conduct that causes property damage, major deceitfulness or theft, and serious rule violations. **Types of aggressive behaviour** **Verbal aggression** (i.e. name-calling, swearing), Physical aggression (i.e. hitting, fighting), **Hostile aggression** (i.e. directed at inflicting injury to others) **Proactive aggression** (i.e. dominating and bullying others without provocation).

10. **Neurodevelopmental Disorders: Manifested at an early age before schooling**

Attention-deficit Hyperactivity Disorder (ADHD)-	**Autism Spectrum Disorder**	**Intellectual Disability Disorder**
Inattentive- Find it difficult to sustain mental effort during work or play or in following instructions. Cannot concentrate, is disorganized, easily distracted, forgetful, does not finish assignments, and is quick to lose interest in boring activities. **Impulsive**- unable to control their immediate reactions or to think before they act. They find it difficult to wait or take turns, have difficulty resisting immediate temptations or delaying gratification. Minor mishaps or more serious accidents and injuries can also occur. **Hyperactivity –** They are in constant motion. Sitting still through a lesson is impossible for them. The c may fidget, squirm, climb and run around the room aimlessly. Parents and teachers describe them as 'driven by a motor', always on the go, and talk incessantly. Boys are four times more likely to be given this diagnosis than girls.	Difficulties in **social interaction** and communication, a **restricted range of interests**, and strong desire for routine. About **70 per cent** of children with autism are also **mentally retarded.** They are unable to initiate social behaviour and seem **unresponsive to other people's feelings.** They are unable to share experiences or emotions with others. Many autistic children never develop speech and those who do, have **repetitive and deviant speech patterns.** repetitive behaviours such as lining up objects or **stereotyped body movements** such as rocking, which can be self- injurious.	Below average intellectual functioning (with an IQ of approximately 70 or below), and deficits or impairments in adaptive behaviour (i.e. in the areas of communication, self-care, home living, social/interpersonal skills, functional academic skills, work, etc.) which are manifested before the age of 18 years. Refer Table 4.2, page 85 **Specific learning disorder** the individual experience difficulty in perceiving or processing information efficiently and accurately. - These get manifested during early school years and the individual encounters problems in basic skills in reading, writing and/or mathematics. The affected child tends to perform below average for her/his age. However, individuals may be able to reach acceptable performance levels with additional inputs and efforts. Specific learning disorder is likely to impair functioning and performance in activities/occupations dependent on the related skills.

11. Feeding & Eating Disorder

Anorexia Nervosa- the individual has a distorted body image that leads her/him to see herself/himself as overweight. Often refusing to eat, exercising compulsively. may lose large amounts of weight and even starve herself/himself to death.

Bulimia nervosa- the individual may eat excessive amounts of food, then purge her/ his body of food by using medicines such as laxatives or diuretics or by vomiting. A sense of tension and negative emotions after purging.

Binge eating- there are frequent episodes of out-of-control eating.

12. Substance Related And Addictive Disorder:

ALCOHOL	**HEROIN**	**COCAINE**
People who abuse alcohol drink large amounts and rely on it to help them face difficult situations. Eventually, the drinking interferes with their social behaviour and ability to think and work. Their bodies built up **tolerance** for alcohol and they need to drink large amounts to feel its effect. They also feel withdrawal symptoms when they stop drinking. Alcohol destroys millions of families, social relationships and careers. It also has serious effects on the children of persons with this disorder. These children have higher rates of psychological problems, particularly anxiety, depression, phobias and substance abuse related disorders. Refer to page 85 box for more effects of alcohol.	Heroin intake significantly interferes with social and occupational functioning. Most abusers further develop a dependence on heroin, revolving their lives around the substance, building up a tolerance for it, and experiencing a withdrawal reaction when they stop taking it.- The most direct danger of heroin abuse is an overdose, which slows down the respiratory centers in the brain, almost paralyzing breathing and in many cases causing deaths.	Regular use of cocaine may lead to a pattern of abuse in which the person may be intoxicated throughout the day and function poorly in social relationships and at work. May also cause problems of short term memory and attention. Dependence may develop, so that cocaine dominates the person's life, more of the drug is needed to get the desired effects, and stopping it results in feelings of depression, fatigue, sleep problems, irritability and anxiety. Cocaine poses serious dangers. It has dangerous effects on psychological functioning and physical well-being.

Commonly Abused Substances (According to DSM-5 Clssification)

Alcohol: (refer box 4.2, page 86 for effects of alcohol)

Amphetamines: Diet pills.

Caffeine: Coffee, tea, caffeinated soda, analgesics (pain killers), chocolate, cocoa. Cannabis: Marijuana or "bhang", hashish.

Cocaine:

Hallucinogens: LSD

Inhalants: Gasoline, glue, paint thinners, spray paints, typewriter correction fluid, sprays. Nicotine: Cigarettes and tobacco.

Opiods: Morphine, heroin, cough syrup, painkiller (analgesic, anesthetics). Phencyclidine

Sedatives, Hypnotics or Anxiolytics : sleeping pills, anti-anxiety medication

IMPORTANT: The notes are basic guidelines of the chapter and the guidelines for framing the answers. Please note the answers are to be detailed as given in the NCERT. Kindly do not only depend on the notes for the course and the subject content. You need to be well versed with the NCERT as well.

- **You can click on the following links on the further explanation for the topics discussed above:**
  https://www.youtube.com/watch?v=FZrFTi5jz8M
  https://www.youtube.com/watch?v=WjIXy1z5838
  https://www.youtube.com/watch?v=O2SfhQNUi7A
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